Complete Summary

GUIDELINE TITLE

Evidence-based protocol. Interpreter facilitation for persons with limited English proficiency.

BIBLIOGRAPHIC SOURCE(S)

Enslein J, Tripp-Reimer T, Kelley LS, Choi E, McCarty L. Evidence-based protocol. Interpreter facilitation for persons with limited English proficiency. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2001 Apr. 32 p. [39 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Limited English proficiency

GUIDELINE CATEGORY

Management
Risk Assessment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses

GUIDELINE OBJECTIVE(S)

To provide information to facilitate the effective use of language interpretation services in health care settings for persons with limited English proficiency

This protocol does not address the use of sign language interpretation for hearing impaired clients.

TARGET POPULATION

Persons in health care settings with limited English proficiency

INTERVENTIONS AND PRACTICES CONSIDERED

1. Identifying individuals at risk for limited English proficiency
2. Using judgment to assess limited English proficiency
3. Selecting an interpreter
4. Preparing an interpreter before interview
5. Facilitating effective communication through interpreter during an interview

MAJOR OUTCOMES CONSIDERED

- Rates of clients assessed for English proficiency
- Rates of use of interpreters
- Patient and provider satisfaction
- Differences in patient diagnoses between interpreted and non-interpreted encounters
- Rates of information recall
- Accuracy of communication and negative effects attributed to disparate languages

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline, CINAHL databases, and reference lists of published materials were searched.

NUMBER OF SOURCE DOCUMENTS

56 English-language publications that pertained primarily to health care interpretation were found.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

A. Evidence from well-designed meta-analysis
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment)
C. Evidence from observational studies (e.g., correlational, descriptive studies) or controlled trials with inconsistent results
D. Evidence from expert opinion or multiple case reports

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline was reviewed by series editor Marita G. Titler, PhD, RN, FAAN and content experts Juliene Lipson, PHD, RN and Noel J. Chrisman, PhD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Indications for Use of An Interpreter

Clients and providers enter the health care setting with varying degrees of proficiency in secondary languages. The following criteria indicate the need for use of an interpreter in the health care exchange:

1. When the client and practitioner speak different languages (Villarruel, Portillo, & Kane, 1999, Evidence Grade = D).
2. When the client has limited understanding of the practitioner´s language; usually this is limited English proficiency. A basic understanding of English may not be sufficient to understand technical information, especially when the client is stressed (Villarruel, Portillo, & Kane, 1999, Evidence Grade = D).
3. When the practitioner has only a rudimentary understanding of the client´s primary language (Putsch, 1985, Evidence Grade = D).
4. When cultural tradition prohibits the client from speaking directly to the practitioner (Diaz-Duque, 1982, 1999, Evidence Grade = D).
5. At all key decision-making points in the health care process (i.e. history taking, prescribing and evaluating therapeutic procedures, before changes in treatment). This ensures informed consent and patient safety, and enables the patient to participate in planning culturally appropriate care that facilitates compliance (Muecke, 1983, Evidence Grade = D).

Individuals at Risk for Limited English Proficiency

Individuals with limited English proficiency are those people who do not speak or understand any English, as well as those who demonstrate some degree of inability to understand or speak English. First generation immigrants to the United States are at highest risk; however that alone is not a sufficient criterion because the person may have migrated from an English-speaking nation or acquired proficiency since immigration. The following individuals may be at risk:

- First generation immigrants whose primary language is other than English.
- Second or later generation immigrants who reside in ethnic enclaves and speak a primary language other than English at home.

Assessment of Limited English Proficiency (see Appendix D in the original guideline document)

Assessment of a client´s command of English is the responsibility of the health care provider. It is a process that depends upon the judgment of the provider rather than a standardized tool. The following cues may indicate a lack of understanding (Diaz-Duque, 1982, 1999; Westby, 2000, Evidence Grade = D)

- Client states that she/he speaks little or no English.

- Client requests or brings an interpreter.
- Client nods or says "yes" to all of the provider´s comments and questions. This may be a culturally based demonstration of respect, or it may reflect a lack of understanding.
- Client incorrectly uses the negative case, such as when using double negatives. This is common in a secondary language.
- Client speaks a language other than English at home. This is a strong indicator of proficiency, because the language spoken at home is the language in which the person expresses emotions and has the largest vocabulary. If English is not the language used at home, the person may lack the vocabulary for self-expression, especially regarding emotional status and sensitive topics.
- Client speaks a language other than English with friends.
- Client´s preferred language for reading is other than English. This may indicate the person´s limited English vocabulary. However, many professionals trained in other countries read English well because English language textbooks are frequently used for advanced education. Thus, the client may comprehend written English better than spoken English.
- Client has a brief residence in the United States. However, a long length of residence alone is not a good indicator of proficiency, because many immigrants live in communities composed of people from the same homeland and may speak only the primary language.
- Client is unable to explain or demonstrate key information. An appropriate method of assessment is for the provider to ask the client to summarize important aspects of information that the provider has told them during the encounter. Inability to repeat the information suggests a lack of understanding.

Description of the Practice

Clients interviewed through interpreters are more satisfied with care received than those who receive no interpretation (Kline et al., 1980). If utilized correctly, interpreters can enhance communication among health care providers, clients and family members. Providers are responsible for establishing the framework in which the interpretation occurs. By following the guidelines below, the providers can facilitate the interpreted exchange.

Selection of an Interpreter

Selection of an appropriate interpreter is essential to accurate, open communication. Not all people can interpret with the same proficiency, thus the health care provider is responsible for selecting the best available interpreter.

Although law mandates that interpretation services be made available at no cost to clients with limited English proficiency, it is not specified how those services should be conducted nor the qualifications of the interpreters. Several options for interpretation exist, however choices may be limited due to cost or availability at the time.

- Use trained and professional interpreters. Trained, professional interpreters are able to provide accurate, reliable interpretations between clients and health care providers. They have a basic understanding of medical

terminology, health care ethics and confidentiality, and the importance of neutrality and precision of interpretation. Use of professional interpreters produces high levels of patient and provider satisfaction (Hornberger, Itakura, & Wilson, 1997; Kuo & Fagan, 1999, Evidence Grade = C).

- Try to use an interpreter of the same sex, age and social status as the client, especially if sensitive information is involved (Diaz-Duque, 1982, 1999, Evidence Grade = D).
- Avoid using untrained interpreters because of increased distortions of the actual message due to omitting information, adding information, simplifying the message, and substituting concepts (Macros, 1979; Vasquez & Javier, 1991, Evidence Grade = C).
- Avoid using family members as interpreters unless it is the client´s preference. Relatives may be too emotionally involved (e.g., a husband interpreting a diagnosis of cancer to his wife), or may be suppressing information about family relationships (e.g., abusive spouses). Power differences may be created that interfere with parent-child relationship or elder-youth status. The client may be unwilling to reveal some health information (e.g., abortion or sexual history) to the family (Buchwald et al., 1993; Lee, 1997, Evidence Grade = D).
- Use of children, especially young children, as interpreters is strongly discouraged because of culturally-based barriers to discussion of certain topics across genders or age hierarchies, and lack of sufficient language proficiency in one or both languages (Haffner, 1992; Jackson, 1998; Villarruel, Portillo, & Kane, 1999, Evidence Grade = D).
- Providers can advocate for development of on-staff interpreter services and access to telephone interpretation services (Villarruel, Portillo, & Kane, 1999, Evidence Grade = D).
- See Appendix E in the original guideline document for the strengths and limitations of various types of interpreters that may be available to the provider.

<u>Before the Interpretation Session</u>

The health care provider should allow time to prepare the interpreter before beginning the interview. This will build trust and clarify expectations.

- Identify the relationship between the client and interpreter. Knowing family relationships may give insight into power and communication dynamics. Even if they are not relatives, the interpreter may know the client because many ethnic communities are small, with everyone knowing all of the members. As a result, clients may fear that exchanges will be shared within the ethnic community. Also, the individuals´ social and political status in their homeland may be barriers to honest, open communication (Buchwald et al., 1993; Chrisman & Zimmer, 2000; Lee, 1997, Evidence Grade = D).
- Review the content of the session, especially sensitive topics (e.g., mental status or sexual conduct). This allows the interpreter time to ask questions, clarify terminology or express discomfort about discussing certain topics (Lee, 1997, Evidence Grade = D).
- Clarify the role of the interpreter. The provider should explain that the interpreter is to function as a voice to repeat the questions and responses of the provider and client without giving additional information, paraphrasing, or polishing with professional terminology. Unless otherwise specified, the

interpreter is not expected to be a culture broker for the health care system nor the client´s culture. If the interpreter perceives that a question should be modified to make it acceptable or a situation needs clarification, the interpreter should discuss it with the provider (Villarruel, Portillo, & Kane, 1999, Evidence Grade = D).

- Explain the need for precise interpretation. The interpreter should repeat the questions and responses so as to maintain the same meaning, tone, and register as the original message. Nothing should be omitted, and nothing should be added unless it is only to explain a word/phrase that the client does not understand. The health care provider wants to know as close as possible what the client said and the emotional tone that the client´s message conveys. This approach will most accurately portray the client´s understanding and emotional state (Diaz-Duque, 1982, 1999; Marcos, 1979, Evidence Grade = C).
- Explain that the interpreter may ask for clarification of information at any time, and may encourage the client to ask questions. (Buchwald et al., 1993; Lee, 1997, Evidence Grade = D).

<u>During the Client Session</u>

During the interview, the healthcare provider may facilitate effective communication by using the following guidelines (Buchwald et al., 1993; Chrisman & Zimmer, 2000; Department of Social Services, 1999; Lee, 1997, Evidence Grade = C)

- Allow sufficient time. It will take 2 to 3 times longer than a standard interview or verbal instruction.
- Ask the interpreter to sit to the side with the client and health care provider facing each other.
- Introduce yourself to the client. Then introduce yourself and client to the interpreter.
- Follow conventions of etiquette to show respect (e.g., stand up when the person enters, shake hands, and use titles such as Mr. And Mrs.)
- Speak to the client, not the interpreter. Address questions to the client as "you" rather than to the interpreter as "he" or "she."
- Use short, simple sentences with fewer than 16 basic words.
- Ask one question at a time.
- Use active words rather than passive voice (e.g., "I will examine your abdomen" rather than "Your abdomen needs to be examined").
- Avoid metaphors (e.g., like a maze), colloquialisms (e.g., pull yourself up by our bootstraps), and idioms (e.g., he is a brother) because such phrases are unlikely to have equivalents in the second language.
- Avoid subjunctive mood (verbs with could or would) because not all language have a subjunctive mood.
- Reword key concepts to provide redundancy. Repetition is an effective communication method.
- Use specific rather than general terms (e.g., daily rather than frequent).
- Avoid medical terminology unless you know that the interpreter and client would be familiar with the equivalent term. It is the practitioner´s responsibility to explain terminology (e.g., work up, or CT scan), not the interpreter´s role.

- Use diagrams, pictures, and translated written materials to increase understanding. Prescription information and detailed instructions should be translated into the clients´ language. If the client is illiterate, provide instructions in both English and the primary language because others in the support network may read for the client, or provide the instructions on audiotape or videotape.
- When speaking or listening, primarily watch the client rather than the interpreter so that non-verbal messages can be observed. This can be accomplished by having the interpreter sit next to the practitioner and across from the client.
- Be aware of non-verbal communication and verify its meaning in the client´s culture.
- Be aware of your own non-verbal communication. For example, norms for direct eye contact, touch, and proximity often differ among cultures.
- Be culturally sensitive and knowledgeable, but do not stereotype. The best source of information on cultural appropriateness is the client. Conduct a cultural assessment to determine the clients´ cultural beliefs. Invite correction of your understanding of information, and admit ignorance of the client´s culture.
- Do not make comments that you do not want interpreted. The client may understand more than you realize.
- Do not ask the interpreter about the client´s history or state of mind. The interpreter may not know the person´s history and probably will not have the expertise to judge someone´s mental state.

Definitions:

Evidence Grading

A. Evidence from well-designed meta-analysis.
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment).
C. Evidence from observational studies (e.g., correlational, descriptive studies) or controlled trials with inconsistent results.
D. Evidence from expert opinion or multiple case reports.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Guideline implementation may help the nurse facilitate the effective use of language interpretation services in health care settings for persons with limited English proficiency, as reflected by increasing the use of interpreters, enhancing the communication process between clients and providers through effective use of interpreters, and improving the satisfaction of clients and providers in health care encounters.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This evidence-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

To evaluate the impact of this protocol, both outcome and process factors should be evaluated.

Process Factors

A sample of healthcare providers who are using the interpreter Facilitation Protocol should be given the Process Evaluation Monitor (see Appendix F in the original guideline document). The purpose of this monitor is to assess the provider´s understanding of and support for carrying out the protocol with clients.

All providers should be given the Provider Knowledge Assessment Test (see Appendix G in the original guideline document). The purpose of the test is to assess the provider´s knowledge of the protocol.

Outcome Factors

To document the success of the Interpreter Facilitation Protocol, the Outcome Evaluation Form (see Appendix H in the original guideline document) should be used. The evaluation form may be adapted to the individual agency. To determine the effectiveness for the intervention some or all of the following changes may be evaluated:

- Percentage of clients assessed for English proficiency

- Percentage of client-provider contacts utilizing an interpreter
- Percentage of client-provider contacts utilizing a trained interpreter
- Percentage of clients satisfied with the care received
- Percentage of providers comfortable with using interpreters
- Percentage of providers satisfied with their communications with clients who have limited English proficiency
- Percentage of clients with "acceptable" levels of knowledge following health education instruction
- To monitor agency outcomes for Interpreter Facilitation for Persons with Limited English Proficiency, the Agency Outcomes Monitor (see Appendix I in the original guideline document) should be used on a routine basis.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Enslein J, Tripp-Reimer T, Kelley LS, Choi E, McCarty L. Evidence-based protocol. Interpreter facilitation for persons with limited English proficiency. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2001 Apr. 32 p. [39 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Apr

GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core - Academic Institution

SOURCE(S) OF FUNDING

This guideline was developed with the support provided by Grant #P30 NRO3979, National Institute of Nursing Research (NINR), National Institutes of Health (NIH).

GUIDELINE COMMITTEE

Members of University of Iowa College of Nursing

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Author(s): Janet Enslein, MA, RN; Toni Tripp-Reimer, PhD, RN, FAAN; Lisa Skemp Kelley, MA RN; Eunice Choi, DNSc, RN; Laura McCarty, BSN, RN

Series Editor: Marita G. Titler, PhD, RN, FAAN

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 6, 2002. The information was verified by the guideline developer as of March 13, 2002.

COPYRIGHT STATEMENT

Web site and/or transferred to an electronic storage and retrieval system solely for the personal use of the individual downloading and transferring the material. Permission for all other uses must be obtained by contacting the University of Iowa Gerontological Nursing Intervention Research Core.

Date Modified: 11/8/2004